ADMINISTRATIVE SERVICES AGREEMENT
By and between

MONTGOMERY COUNTY GOVERNMENT

and
Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

JANUARY 1, 2004 AMENDMENT
Out-of-Service Area Plan

This amendment is effective January 1, 2004. Notwithstanding any provision, exclusion or reference to the contrary, the Contract is amended as follows:

All references to the Maryland Insurance Administration in the Certificate of Coverage are herby deleted.

APPEALS AND GRIEVANCES

The Certificate of Coverage, Section 6, Customer Satisfaction Procedures and any references to the Grievance and Appeals Procedures is deleted and replaced by the following:

CareFirst's appeal procedure is designed to enable you to have your concerns regarding a denial of benefits or authorization for services heard and resolved. By following the steps outlined below, you can ensure that your appeal is quickly and responsively addressed. *Refer to your Evidence of Coverage for more specific information regarding your appeal process.*

An expedited appeal process has been established in the event that a delay in a decision would be detrimental to your health or the health of a covered family member. In an expedited appeal, a decision by CareFirst shall be made within 24 hours, and review will be done by a peer of the patient's treating healthcare provider, if additional information would not change the Plan's decision. Expedited Appeals involve care that has not yet occurred or is currently occurring. (Pre Service or concurrent care).

Step 1: Discussion of the Problem
Your concerns can often be handled and resolved through informal discussions and information gathering. If your question relates to our handling of a claim or other administrative action, call and discuss the matter with a CareFirst member services representative. In many instances, the matter can be quickly resolved.

Step 2: Appeal/ Grievance Process
If your concern is not resolved through a discussion with a CareFirst representative, you or someone on your behalf may make a formal request for appeal. CareFirst must receive the request within 180 days or six months of the date of the notification of denial of benefits or services. If the request for appeal is related to a medical issue, a peer of the patient's treating health care provider, not part of the original denial decision, will review the request. This request should be in writing and addressed to the Member Services Department, and shall state the reason of the request. A Member Services representative will be

available to assist you in submitting your appeal in the event you are unable to put the request in writing. All appeal decisions will be rendered in writing to the member, and include a detailed explanation as to the reason for the decision, and any supporting documentation to show how that decision was made. Included in this written appeal decision will be an explanation of the appropriate next steps a member may take if they are not satisfied with the appeal decision.

SEAMLESS POS AMENDMENT

All references to the Seamless POS Amendment in the Certificate of Coverage are herby deleted.

This amendment is subject to all the terms and conditions of the Group Contract and Certificate of Coverage to which this Amendment applies. This amendment does not change the terms and conditions of the evidence of coverage, unless specifically stated herein.

Group Hospitalization and Medical Services, Inc.

William L. Jews
President and Chief Executive Officer